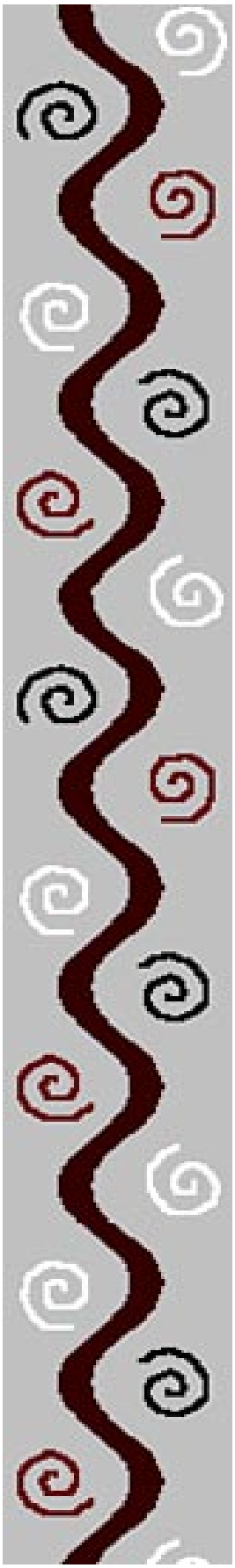
HEALTH REFORM TOOLS



Partnerships for Health Reform

PHR

A Glossary of Health Terms

Health
Santé
SALUD

FOR TRANSLATORS

English ■ French ■ Spanish

Benefits
Prestations
PRESTACIONES

Acuity
Gravité
GRAVIDAD

Access
Accès
ACCESO

Abt

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Mission

The Partnerships for Health Reform (PHR) Project seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- *Better informed and more participatory policy processes in health sector reform;*
- *More equitable and sustainable health financing systems;*
- *Improved incentives within health systems to encourage agents to use and deliver efficient and quality health services; and*
- *Enhanced organization and management of health care systems and institutions to support specific health sector reforms.*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

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This list of terms and translations is intended to be used as a guide and not as a definitive source of exact translations or definitions. PHR recognizes that terms can be defined and translated many ways according to prevalent customs in different regions and within different health disciplines. This compilation, which has undergone peer review, is offered as a guide and should be recognized as a "working document." Your suggestions and comments are welcome. Please send them to:

PHR Resource Center
Abt Associates Inc.
4800 Montgomery Lane, Suite 600
Bethesda, Maryland 20814 USA

Email: glossary@PHRproject.com

Access

Accès
Acceso

The presence or absence of physical, economic, or cultural barriers that people might face in using health services. Physical barriers are usually interpreted to mean those related to the general supply and availability of health services and distance from health facilities. Economic barriers are usually interpreted to mean those related to the cost of seeking and obtaining health care, in relation to a patient's or household's income.[10] Cultural barriers relate to social or community perceptions about receiving or knowing about certain health services.

Acuity

Gravité
Gravedad

A measurement of patient severity of illness that is related to the amount of resources required to care for the patient.

Acute v. Chronic Disease

Maladie aiguë, par opposition à maladie chronique
Enfermedad de carácter agudo versus crónico

A disease that normally is of short duration--a rule of thumb is 30 days or less--and that ordinarily is confined to a single episode. Chronic diseases typically violate one or both of these criteria, but the distinction is not hard and fast.

Adverse Selection

Antisélection
Selección adversa

(1) Tendency of people more likely to incur health costs to seek health insurance. (The opposite is favorable selection.) (2) A situation in which patients with greater than average need for medical and hospital care enroll in a prepaid health care plan in greater numbers than they occur in a cross-section of the population. A plan enrolling only the Medicare population would suffer from adverse selection, as would one that somehow encouraged or allowed people to sign up when they were already ill.

Allocative Efficiency

Efficacité de la répartition
Eficiencia de asignación

The extent of optimality in distribution of resources among a number of competing uses.[3]

ALOS/LOS

Durée moyenne du séjour/durée du séjour (DMS/DS)
Estadía promdio/Estadía

Average length of stay. (1) The total days of stay (during their entire hospitalizations) of all patients in the specified group or institution discharged during a given time period, divided by the number of patients discharged during that same time period.

(2) A standard hospital statistic. For a given group of patients, their total stays are added together, and that total is divided by the total number of patients in the group. For a hospital ALOS, the formula adds together the lengths of stay of all patients discharged from the hospital (for their entire stays) in a given time period,

and divides that sum by the number of patients discharged in that time period. ALOS is often incorrectly referred to as "LOS"; that abbreviation means "length of stay" and pertains to an individual patient.

The ALOS may be calculated not only for the entire hospital, but also for specific age groups and diagnosis groups, for example. It may also be calculated in a more refined (normalized) manner by "adjusting" for the case mix of the hospital. An ALOS that adjusts for the age distribution of the patients, for example, makes for more fair comparisons between hospitals than does one without such adjustment; and additional factors, such as the distribution of patients among diagnosis groups, further improves the statistic for interhospital comparison purposes.

Appropriation Budget

Crédits alloués
Presupuesto asignado

Type of budget commonly associated with government agencies and characterized by an authorized spending level for a specified period.

Assessment

Evaluation
Evaluación

The collection, analysis, and evaluation of information about a project.

Average cost

Coût moyen
Costo promedio

Full costs divided by the volume or frequency of the cost object.

Bad Debt

Créance irrécouvrable
Deuda incobrable

A payment that is unpaid, for example, by patient, insurance fund, or other payor organization.

Bed Days

Jour(s)-lit
Días de cama

Days of inpatient care; one person in the hospital one day is one bed day.

Benchmarks

Seuil à atteindre
Puntos de referencia

The goal or indicator to be attained. It is used to compare current situation with desired end. Benchmarks may pertain to quality, prices, health care practice patterns, financial standing, and most other aspects of running an organization.

Benefit Package

Ensemble de prestations
Paquete de prestaciones

Services covered by a health insurance plan, government budget, or other funding source and the financial terms of such coverage, including cost sharing and limitations on amounts of services.[11]

Benefits

Prestations
Prestaciones

(1) Gains, whether material or not, accruing to an individual or a community.[3] (2) The money,

care, or other services to which an individual is entitled by virtue of insurance.

Break-even Point

Seuil de rentabilité
Punto de equilibrio

The point at which total revenues equals total costs (fixed plus variable costs). The volume at which losses no longer occur and profit begins. Break-even analysis is the determination of the minimum volume or frequency necessary in order for a cost object to be financially self-supporting.

Break-even Time

Seuil de rentabilité dans le temps
Tiempo de equilibrio

Capital budgeting method that measures the time it takes from the start of the project to when the cumulative present value of the cash inflows of a project equals the present value of the total cash outflows. The payback period is similar to break-even time except that it is calculated without net present values.

Budget

Budget
Presupuesto

(1) A detailed plan for the future showing how resources will be acquired and used during a specific time period, expressed in formal, measurable terms. (2) Periodic allocation of funds to (or on the behalf of) health facilities. The total amount of the allocation is determined in advance (prospectively).

Burden of Disease

Charge de la maladie
Carga de la enfermedad

(1) An indicator that quantifies the loss of life from disease; measured in disability-adjusted life years.[3] (2) An indicator that quantifies the loss of health life from disease; measured in disability-adjusted life years.

Capital Budgeting

Préparation du budget d'équipement
Análisis de inversiones

The process of planning expenditures on durable assets that last longer than one year.

Capitation Payment

Paiement à la capitation
Pago per-cápita

(1) A payment made directly to health care providers for individuals who have signed up with that provider to receive a particular package of services. The health care provider is both a fundholder and deliverer of services. Under full-capitation of full-fundholding, the provider assumes responsibility for paying all components of health care (inpatient and outpatient). Under partial-capitation or partial-fundholding, the provider assumes responsibility for paying for only selected services. (2) A method of payment in which a provider receives a fixed fee per person (per capita) for a period of time, and the provider agrees to furnish to persons for whom the capitation payments are received all the care that may be required (within contract limitations) without further fee. Capitation may, for example, pertain to virtually all medical and hospital services through a health care plan, or only to primary care services.

Case-based Payment

Paiement par cas (traité)
Pago por caso específico

A fixed payment covering all services for a specified case or illness. Patient classification systems group patients according to diagnoses, major procedures performed, etc. (e.g., DRGs). Most frequently applied to inpatient services, although outpatient groupers are being developed.

Case-mix

Enveloppe des cas (traités)
Combinación de casos

(1) The mix of different types (defined by severity of illness and complexity of diagnosis and/or treatment) of patients treated in a health care organization. (2) The mix of cases, defined by age, sex, diagnosis, treatments, severity of illness, and so on, handled by a practitioner or hospital. Case mix is defined by: (a) grouping patients according to these factors; and then (b) determining the proportion of the total falling into each group. At present, the most popular group classification is the Diagnosis Related Group (DRG) system. Sometimes the term "case mix" is used, inaccurately, to mean the grouping system itself (DRG, for example). The Medicare prospective payment system (PPS), with a price for each DRG, means that the total revenue for the hospital for its Medicare patients depends on how many "items" it "sells," that is, how many patients are cared for and the DRG of each. The revenue, therefore, is dependent upon the hospital's case mix.

Cash Budget

Budget de trésorerie
Presupuesto de caja

A schedule showing cash flows (receipts, disbursements, and net cash) for an enterprise over a specified period of time.

Catastrophic Coverage

Couverture contre les risques catastrophiques
Cobetura para enfermedades catostróficas

This is insurance intended to pay only those costs that are very unusual in their magnitude.

Charge Master

Barème (des honoraires)
Guía de aranceles

A list of the organization's prices for each of its services.

Claim

Demande de remboursement
Solicitud de reembolso

A claim for the insurer to pay for medical services used by a beneficiary. The claim may be made by the beneficiary or by health care provider.

Classification Coding

Encodage par classification
Codificación clasificadora

Coding in which each "code" (number) represents a class (rubric or category) rather than an individual term. This is the method presently used by hospitals for coding diagnoses and procedures. This coding is done for the indexing of medical records for retrieval and research, and in the submission of case abstracts

for billing. Each diagnosis and procedure is given the code for the group (class) of diagnoses or procedures to which it belongs, rather than a unique code that represents the diagnosis or procedure itself.

Except for "single-diagnosis classes," the case (or diagnosis) cannot be retrieved precisely because decoding retrieves the label of the class or group rather than the specific diagnosis or procedure that was coded. For example, a specific condition such as AIDS (acquired immune deficiency syndrome), which has no class or pigeonhole of its own, is placed in a "waste-basket" of "other immune deficiency disorders;" such a system makes it impossible to determine the exact number of AIDS cases or to retrieve them alone; all cases of "other immune deficiency disorders" are counted and retrieved together.

In the coding system now in use in the United States, which is a classification coding system (ICD-9-CM), some 40,000 diagnoses are forced into 11,000 groups or classes; further detail is lost when these classes, in turn, go into the 468 DRGs.

Clinical Database

Base de données cliniques
Base de datos clínica

The array of information (data set) that the physician collects on a patient in order to make a diagnosis and to be able to detect changes in the patient's condition during treatment and as the disease itself and the healing progress. See also international minimum basic data set.

Clinical Practice Guidelines

Directives de pratique clinique
Directrices de prácticas clínicas

Codified approaches to medical care. Guidelines may be used for both diagnostic and therapeutic modalities, and they may be used to guide physicians in the care of patients with defined diseases or symptoms or as surveillance tools to monitor practice on a retrospective basis.

Code

Code
Código

A shorthand representation for something. Codes may be used on a patient's bill, for example, to indicate the service for which a charge is shown. Diagnoses and procedures are commonly coded for ease of manipulation by computer (see coding).

Coding

Encodage
Codificación

The process of substituting a symbol (code), usually a number, for a term, such as a diagnosis or procedure. Coding is a clerical function and should only require substituting a code for the term to be coded. However, in many circumstances, the term to be coded will not be found in the coder's reference material, and a judgment will have to be made. In this case, the coder must know the meaning of the term and the way the coding system works, so that proper coding can be done. Under such circumstances, the task is far from clerical, and is one of classification (2) rather than coding.

There are two basic ways to code: ((1) assigning to each individual term its own unique code

(number); and ((2) assigning to each term a code that represents a class, which class may include one or more individual terms. The first technique is called "entity coding;" the second is "classification coding." These are discussed further:

Co-insurance

Co-assurance
Seguro copartícipe

(1) A percentage of the charges for medical care, specified in the policy, that the beneficiary must pay. (2) A type of insurance that requires that part of the charges be paid the beneficiary, the primary purpose being to discourage small claims and "over-use" of services.

Community Financing

Financement communautaire
Financiamento comunitario

Direct financing or co-financing of health care by households in villages or communities, either by payment on receipt of care or by prepayment.[3]

Computer-assisted Encoding

Encodage assisté par ordinateur
Codificación por computadora

A process in which a person (coder) is assisted in coding by a computer. The coder, using a computer keyboard, enters the words of the diagnosis (or other item to be coded) and the computer identifies the correct code. The better systems are "interactive" in that they "prompt" the coder to enter more detailed information, more exact terminology, or additional information in order to find the most precise term and its code. When used for diagnosis or procedure coding in the hospital, the prompting insists on careful study of the medical record, and considerably improves precision over manual coding. For example, "myocardial infarction" is a valid term to label a disease process involving the heart; a more precise term tells which part of the heart is involved, for example, "anterior myocardial infarction." Each of these two terms has its own code, but the more precise code is preferred, and the interactive system prompts the coder to seek the detail (which almost certainly is in the record) needed to use the detailed term rather than the more general term.

Consumer Satisfaction

Satisfaction du consommateur
Satisfacción del consumidor

The overall power that consumers can have in a market to control the nature, quality, and volume of goods and services produced, by the act of purchasing only those goods and services for which they are willing and able to pay. By contrast in a centrally planned economy the goods and services provided are not determined by the mechanism of consumer satisfaction but by central planning decisions. Belief in consumer satisfaction is a notion central to neo-classical western economic theory. It assumes that a market works efficiently insofar as consumers are free to exercise their sovereignty and thus determine what and how much shall be produced in an economy. The market adjusts the supply of goods and services to consumer demand through prices. With complex services like legal services, real estate, equity investment, and health care, it is common for the consumer to work with an agent or "buyer" to advise on the exercise of consumer choice. Some health systems have corporate purchasers at primary care level or covering larger

populations to exercise these functions on behalf of the consumers. The efficient operation of consumer satisfaction whether at individual of corporate level depends upon the consumer having complete knowledge of personal welfare needs and of the market, together with the expertise to discriminate between the quality of different goods and services on offer for the resources available. In certain markets, where monopoly or oligopoly operate, producers are so much more powerful than consumers that they control the market in terms of supply, prices, quality, and delivery. In health care this can be so. But some health systems operate as monopsonies in which a small number of corporate purchasers, such as insurance companies, dominate the market with many competing providers trying to survive.

Continuing Medical Education (CME)

Éducation médicale continue
Educación médica permanente

The education of practicing physicians, through refresher courses, medical journals and texts, attendance at regularly scheduled teaching programs, and so forth. CME programs are provided by medical schools, professional organizations, and hospitals. The necessity of continuing education in these days of rapid scientific advances is well accepted by the medical profession. In some states, CME is required for continued licensure.

Continuous Quality Improvement (CQI)

Amélioration continue de la qualité
Mejoramiento permanente de la calidad

An approach to improving and maintaining quality that emphasizes internally driven and relatively constant (as contrasted with intermittent) assessments of potential causes of quality defects, followed by action aimed either at avoiding decrease in quality or else correcting it in an early stage.

Contracting Out

Sous-traitance
Subcontratación

The practice of the public sector or private firms of employing and financing an outside agent to perform some specific task rather than managing it themselves.

Contribution Margin

Marge de participation
Margen de contribución

The contribution margin represents the difference between the rate or fee charged for a cost object and the variable costs required for providing that cost object. This residual amount, the difference, “contributes” toward covering the fixed costs. A related term often used in break-even analysis. Break-even point formula is (Fixed Costs/(price - variable costs)).

Controllable Costs

Coûts pouvant être maîtrisés
Costos controlables

Those costs that are reasonably under the control of the manager in question. It is often useful to identify which costs are controllable by a given manager and which ones are not. Controllability is a measure of influence over the use or consumption of costs (resources).

Coordination of Benefits (COB)

Coordination des prestations
Coordinación de prestaciones

(1) An insurance claims review process used when a beneficiary is insured by two or more carriers. The process determines the liability of each carrier in order to eliminate duplication of payments. For example, benefits to which an individual is entitled under workers' compensation cannot be duplicated by ordinary health insurance, even though the injury or illness would be covered were the problem not work-related. (2) Action taken by an insurer to ensure that a provider or beneficiary is not paid twice for the same claim.

Copayment

Ticket modérateur
Copago

(1) An arrangement whereby an insured person pays a particular percentage of any bill for health services received, the insurer paying the remainder.[3] (2) A fixed fee per medical service specified in the policy that the beneficiary must pay. (3) An out-of-pocket charge paid by an insured individual at the point of services (in addition to the pre-paid premium). (4) The share of charges for a service for which the beneficiary is responsible under a coinsurance plan.

Cost Accounting

Comptabilité des coûts
Contabilidad de costos

Any coherent system designed to gather and report cost information to the management of an organization.

Cost Allocation Base

Base de répartition des coûts
Base de asignación de costos

Factor (e.g., square meters, FTEs) that is the common denominator for systematically apportioning a cost or group of costs to several cost objects such as department, activity, or procedure.

Cost-Benefit Analysis

Analyse coûts-avantages
Análisis costo-beneficio

(1) A method of comparing the actual and potential costs (both private and social) of various alternative schemes with the actual and potential benefits (private and social), usually measured in monetary terms and present values, with a view to determining which one maximizes the benefits.[3]

Cost Center

Centre de responsabilité pour les coûts
Centro (de determinación) de costos

Responsibility center in which a manager is accountable for the costs (expenses) only.

Cost-Containment/Reduction

Maîtrise des coûts/réduction des coûts
Control/Reducción de costos

Control of medical care expenditures. A variety of methods can be used, such as regulating prices, limiting budgets, capping cost growth rates, utilization management, improving efficiency, etc.

Cost-Effective

D'un bon rapport coût-efficacité
Eficaz en función de los costos

Effective or productive in relation to cost.[3]

Cost-Effectiveness

Coût-efficacité
Eficacia en función de los costos

Effect produced per unit of cost.[12]

Cost-Effectiveness Analysis

Analyse (du) coût-efficacité
Análisis de eficacia en función de los costos

A method of comparing alternative courses of action in order to determine the relative degree to which they will achieve the desired objectives per unit of cost. The costs are expressed in monetary terms but some of the consequences are expressed in physical units, e.g., number of lives saved or cases of disease detected.[3]

Cost Finding

Recherche des coûts
Determinación de costos

A process that finds the costs of unit of service, such as laboratory tests, x-ray or routine patient days, based on an allocation of nonrevenue cost center costs to revenue centers.

Cost Management

Gestion des coûts
Gestión de costos

The performance by executives and others in monitoring and controlling the cost implications of the strategies they are following.

Cost Object

Objet du coût
Objeto de la determinación de costos

The item for which the user is trying to establish a cost. This could be procedures, activities, services, or other items that use or consume resources and are a target of the costing effort. The term "cost object" is a more generic term and holds a greater applicability across the many types of departments. For example, one department might want to cost a given clinical procedure, while another department might want to cost an activity. Both are cost objects.

Cost of Capital

Coût du capital
Costo de capital

The cost to the organization of the money used for acquiring capital. It is often represented by the interest rate that the organization pays on borrowed money.

Cost Recovery

Recouvrement des coûts
Recuperación de costos

Receipt, by a health provider, of income from individuals or the community in exchange for health services.[3]

Cost Sharing

Partage des coûts
Participación en los costos

Usually refers to a method of financing where the costs are divided among multiple payers, e.g., user and employer, government, donor, taxpayer, insurance agency, etc.

Costs

Coûts
Costos

What has to be given up to achieve an objective either the value of the benefits that are foregone in order to achieve that objective (the economic definition), or the total money expenditure required to achieve it (the accounting definition).[3]

Covered Services or Benefits Package

Services couverts ou ensemble de prestations
Servicios cubiertos o Paquete de prestaciones

The types of medical care for which the insurer will pay all or part of the cost. An "Exclusion" refers to care that is not a covered benefit.

Decentralization

Décentralisation
Descentralización

The freedom to make decisions. Total decentralization in an organization means minimum constraints and maximum freedom for managers to make decisions at the lowest levels of an organization.

Deductible

Franchise
Deducible

A fixed sum, specified in an insurance policy, that is deducted from any claim made under that policy (and that is therefore paid by the beneficiary of the policy), the remainder of the claim, or a portion thereof, being paid by the insurer.[13]

Demand

Demande
Demanda

The desire, ability, and willingness of an individual to purchase a good or service. Demand for health care is influenced by prices, education, quality of care, distance from facilities, income level, and religious and cultural factors.

Demand for Health Services

Demande de services de santé
Demanda por servicios de salud

The amount of health care services chosen by individuals. The amount of services chosen depends on characteristics of the individuals, such as income, age, sex, and health status, and characteristics of the provider, such as quality, price, and distance.

Diagnosis Related Group (DRG)

Groupe homogène de diagnostic
Grupo relacionado por diagnóstico (GRD)

(1) A group of cases arranged according to their diagnosis, determined using the International Classification of Diseases. Note: The purpose of grouping is to assist in the comparison of costs or in calculating the price to be charged for each case conforming to a particular pattern or grouping. (2) A hospital patient classification system developed under federal grants at Yale University. The current payment system for Medicare is based on the federal government's setting a predetermined price for the "package of care" in the hospital (exclusive of the physician's fees) for each DRG. If the hospital can provide the care for less than the price, it can keep the "profit." If the care costs the hospital more than the price, the hospital has to

absorb the loss. Originally, each DRG was intended to contain patients that who were roughly the same kind of patients in a medical sense and who spent roughly the same length of time in the hospital. The groupings were subsequently redefined so that, in addition to medical similarity, resource consumption (ancillary services as well as bed days) was roughly the same within a given group. There are now 468 groups identified on the basis of the following criteria: the principal diagnosis (the final diagnosis that, after study in the hospital, was determined to be chiefly responsible for the hospitalization); whether or not an operating room procedure was performed; the patient's age; comorbidity; and complications.

Direct Costs

Coûts directs
Costos directos

Costs clearly and directly associated, traced, or identified to a cost object. Generally, direct costs are the labor resources, medical supplies, equipment costs, and other expenses directly used to produce or deliver a cost object. Examples include nursing time with a patient, medicines, and specific equipment.

Disability Adjusted Life Year (DALY)

Année de vie corrigée du facteur d'invalidité (AVCI)
Años de vida ajustados por la incapacidad

A unit used for measuring both the global burden of disease and the effectiveness of health interventions, as indicated by reductions in the disease burden. It is calculated as the present value of the future years of disability-free life that are lost as a result of the premature deaths or cases of disability occurring in a particular year.[3]

Economic Analysis/Evaluation

Analyse économique/évaluation économique
Análisis/Evaluación económica

In health sector, process whereby costs of programs, alternatives or options are compared with their consequences in terms of improved health or savings in resources.[3]

Effectiveness

Efficacité
Eficacia

The degree or extent to which an activity achieves its objectives.

Efficiency Variance

Variance de l'efficience
Varianza de la eficiencia

Variance due to actual productivity differing from what was budgeted.

Efficiency, economic

Efficience économique
Eficiencia económica

For a given output, what is the minimum cost with which it can be provided.

Efficiency, technical

Efficience technique
Eficiencia técnica

For a given set of inputs (labor and capital), what is the maximum output that can be achieved. For a given output, what is the minimum set of inputs that can be used. This concept is measured in physical/ material units.

Entity Coding

Encodage par entité
Codificación por entidad

Coding in which each "code" (number) represents an individual term (entity) rather than a class. In entity coding, each specific term to be coded (for example, a diagnosis or the name of a procedure) is exchanged for a code (number) that, when decoded, yields exactly the same words (term) that were coded. No detail is lost as is the case in classification coding.

The principle behind entity coding is that classification (2) should be a two-step process: step one, information is coded so that it can be manipulated (usually by a computer); and step two, the coded information is then classified according to the needs of the particular user or demands of a particular classification (1) system. In entity coding, the integrity of the items of information remains intact, and the system can meet the needs of any number of classification systems. For example, a person investigating the frequency of office visits for the common cold would need to have a discrete class for the common cold. Since common colds seldom require hospitalization, however, classifying the cold as "other infectious diseases" might meet the needs of the hospital studying reasons for admission.Environmental Health

Santé du milieu
Salud ambiental

An organized community effort to minimize the public's exposure to environmental hazards by identifying the disease or injury agent, preventing the agent's transmission through the environment, and protecting people from the exposure to contaminated and hazardous environments.[11]

Equity

Equité
Equidad

Not necessarily the same as equality, it relates in general to ethical judgments about the fairness of income and wealth distribution, cost and benefit distributions, accessibility of health services, exposure to health-threatening hazards, and so forth.[3] Several measures are used depending on preferences of the community.

Essential Drugs

Médicaments essentiels
Fármacos básicos

Those therapeutic substances that are indispensable for the rational care of the vast majority of diseases in a given population. A model list of such drugs, including about 250 substances, has been drawn up and is kept under review by a WHO expert committee. It furnishes a basis for countries to establish their own lists in the light of their own priorities and special circumstances. Experience has shown that about 30 to 40 drugs are sufficient for primary health care in many countries, the rest being required for secondary and tertiary health care. Such lists do not mean that no other drugs are useful, but simply that in a given situation those drugs are the most needed for the health care of the majority, and should, therefore, be available at all times in adequate amounts and in the proper dosage forms.

Expenses

Dépenses
Gastos

Costs that have been used or consumed in carrying on some activity.

Fee-for-Service

Paiement à l'acte
Reembolso por atención prestada

(1) Reimbursement of providers on a service-by-service basis rather than on a salaried, per-case or capitated basis.[1] A retrospective payment method where the units of services may be combined as visit packages (e.g., medicines, follow-up visits, tests, etc.). (2) A method of paying physicians (and other health care providers) in which each "service," for example, a doctor's office visit or operation, carries a fee. The physician's income under this system is made up from the fees she collects for services. Alternative methods of income for physicians are: (a) a salary, as from an HMO (health maintenance organization); and (b) a "capitation" payment system, in which the physician is paid a predetermined amount for each patient for which she assumes responsibility for a given period of time (rather than each service rendered). The capitation method can, of course, be applied via some type of health care organization, for example, an HMO, in which case the capitation payment is made to the HMO, with the physician paid in the manner decided by the HMO.

Financial Accounting

Comptabilité financière
Contabilidad general

Focuses on standard accounting techniques and how they are used to report to external decision makers (e.g., government). Methods follow legal and generally accepted accounting principles.

Fixed Budgeting

Budgétisation fixe
Presupuesto no ajustable

A budget that is not adjusted or altered after it is drawn up, regardless of changes in volume, cost drivers, or other conditions during the budget period.

Fixed Costs

Coûts fixes
Costos fijos

Those costs that do not vary with fluctuations in volume, frequency, or activity. The depreciation cost or fixed monthly rent of a building that houses varying volumes of patients does not change as the volume or frequency of patient visits fluctuates.

Flexible Budget

Budget souple
Presupuesto flexible

Budget that takes into account the fact that certain costs vary with the level of activity or volume and other costs remain fixed over a relevant range of activity. Flexible budgets anticipate the possibility of change and show planned revenues and planned expenses at various levels of volume.

Flexible Budget Variance

Variance d'un budget souple
Varianza del presupuesto flexible

The difference between actual results and the flexible-budget amounts adjusted for the actual volume achieved.

Full-time Equivalent

Equivalent plein-temps
Equivalencia de jornada completa

The equivalent of one full-time employee paid for one year, including both productive and nonproductive (e.g., vacation, sick, holidays, etc.) time.

Fully Absorbed Costs

Coûts amortis
Costos aplicados integralmente

Includes all costs direct and indirect and allocated overhead. A cost object that is fully costed is said to be one that has had all of these costs identified, attributed, or allocated to that cost object.

Funder

Source de financement
Financista

The entity responsible for funding health and disability support services, e.g., government, private or public insurance, provider, etc.

Fund or Fundholder

Fonds ou détenteur de fonds
Fondo o Tenedor de fondos

The institution responsible for accumulating and spending the (prepaid) contributions for insurance (see purchaser). Funds are usually third party payers (public or private) but can also be providers. In the latter case, some functions of insurer and provider are integrated in a single institution.

Gatekeeper

Portier
Coordinador de atención primaria

(1) A primary care provider, e.g., family physician, general practitioner, or nurse practitioner, who is responsible for coordinating some or all non-emergency treatment provided for individuals enrolled in some kind of health insurance plan (public or private). Not all health insurance programs require this feature. (2) The former term for patient care manager, an individual who comes between the patient and secondary (specialist) care. This is one role of a primary care physician. Some health care systems, such as in Great Britain, prohibit the patient from making the initial contact with the specialist; without a referral from the general practitioner (that is, the gatekeeper or patient care manager), the specialist may not see the patient.

Gatekeeper Function

Fonction de filtrage
Función de coordinador de atención primaria

An accepted role of a particular professional or organizational unit (e.g., at the primary care level) through whom other, often expensive or scarce, care resources are accessed. Thus a person needing consultant medical skills in the UK can only obtain these if referred by a family doctor.

General Practitioner

Généraliste
Médico general

A physician whose tasks are to provide people with comprehensive health care from the beginning of life to death and to advise them on all aspects of health, irrespective of age, sex, ethnic group, or religious beliefs. Note: The general practitioner's task begins with prevention and extends right up to rehabilitation, taking into account special knowledge of the patient's family, professional and social circumstances. The general practitioner works in close proximity with the people, is the first doctor to be consulted, has an overall knowledge of the patient, his or her environment and circumstances and thus remains the family doctor.

General Practitioner Fundholding

Fonds de généralistes
Tenencia de fondos de médicos generales

Giving to a group of general practitioners the financial and managerial responsibility for paying for a defined range of medical or other services for the patients under their care. This allows the GP to pay others (hospitals etc.) or to employ staff to do the work.

Global Budget

Budget global
Presupuesto global

A prospective payment method where the unit of service is either a political entity or health facility. Total payment is fixed in advance to cover a specified period of time. Some end of year adjustments may be allowed. Various formulas can be used historical budgets, per capita rates with various adjustments (e.g., age, sex, etc.).

Health Care Provider

Prestataire de soins (de santé)
Proveedor de atención de salud

An individual or institution that provides medical services (e.g., a physician, hospital, laboratory). This term should not be confused with an insurance company which "provides" insurance.[11]

Health Economics

Economie de la santé
Economía de la salud

The application of economic theory to phenomena and problems associated with health and health services. Topics include, among others, the meaning and measurement of health status, the production of health and health services, the demand for health and demand for health services, cost effectiveness and cost-benefit analysis in the health field, health insurance, the analysis of markets for health services, financing of health services, disease costing, option appraisal in health services, planning of human resources, the economics of medical supply industries, the determinants of inequalities in health and health care utilization, hospital economics, health care budgeting, territorial resource allocation, and methods of remuneration of medical personnel.[3]

Health Financing

Financement de la santé
Financiamiento de la salud

The system of fund generation, fund expenditures, and flow of funds used to support the health care delivery system.

Health Insurance

Assurance-maladie
Seguro médico

A system of funding set up in advance to pool resources of many individuals as a means to pay for unexpected and usually large health care expenditures required by some individuals in the contractual arrangement.

Health Investment

Investissement pour la santé
Inversión en salud

Expenditure on equipment and human resources used to provide health services and promote health. In a more general sense, the undertaking of any activity that involves a sacrifice (e.g., payment of money), followed by a benefit (e.g., enjoyment of a good).[3]

Health Maintenance Organization (HMO)

Réseau de soins coordonnés (RSC)
Organización de mantenimiento de la salud

(1) A prepaid, organized health care service delivery arrangement in which beneficiaries receive services through a system of affiliated hospitals, clinics, physicians, etc. Comprehensive benefits are financed by prepaid premiums and limited copayments.[1] Services rendered are carefully managed to control what services a patient receives. (2) A health care providing organization that ordinarily has a closed group of physicians (and sometimes other health care professionals) along with either its own hospital or allocated beds in one or more hospitals. Patients "join" an HMO, which agrees to provide "all" the medical and hospital care they need, under a contract stipulating the limits of the service, for a fixed, predetermined fee. An S/HMO (social/health maintenance organization) is a new type of long term care "alternative" organization under experimentation in which one provider, under a capitation payment (a fixed fee for each individual covered), furnishes both social and health care services for low income individuals.

Health Outcome

Résultat médical
Resultados de salud

(1) The consequence of a medical intervention on a patient.[11] (2) Final consequence or result; a recorded change in the well-being of a consumer that is presumed to be or to have been caused by a health care event.[12]

Health Sector Reform

Réforme du secteur de la santé
Reforma del sector salud

(1) A process that seeks major changes in national policies, programs, and practices through changes in health sector priorities, laws, regulations, organizational structure, and financing arrangements. The central goals are most often to improve access, equity, quality, efficiency, and/or sustainability.[4] (2) A sustained process of fundamental change in policy and institutional arrangements, guided by government, designed to improve the functioning and performance of the health sector and ultimately the health status of the population. Health sector reform is concerned with defining priorities, refining policies, and reforming the institutions through which those policies are implemented.[14]

Health Status

État de santé
Estados de salud

The state of health of an individual, group or population. Numerous internationally accepted measures (e.g., mortality rates) can be used.

Incentives

Incitations
Incentivos

(1) Factors that motivate a person or group to behave in a certain way. (2) Rewards for desired behavior. Now used regarding rewards for decreasing hospital and physician costs, and for encouraging patients to be frugal in demands for health care. Sometimes incentives are negative, for example, when a patient is required to pay the first dollars for a service (deductibles). This is a "disincentive" to seek the care, and thus an incentive to be frugal.

Indemnity Benefits

Prestations sous forme d'indemnités
Prestaciones de indemnizaciones

Insurance benefits that are provided in cash to the beneficiary rather than in service (service benefits). Indemnity benefits are usual with commercial insurance.

Indicator

Indicateur
Indicador

A quantitative measure for monitoring any aspect of a process or outcome.

Indirect Costs

Coûts indirects
Costos indirectos

Those costs that cannot be directly traced, identified, linked, or associated with a cost object in an economically feasible way. Some arbitrary method of tracing the cost to the cost object is required. Indirect costs typically include office supplies and most management costs that are not specifically linked (hands-on patient or direct activity), administrative time, general overhead, etc. Indirect costs can be reclassified as direct costs if extra detailed calculations are made; however, the actual costs of performing these calculations may not merit the value of defining these direct costs.

Indirect Costs (allocated)

Coûts indirects (alloués)
Costos indirectos (asignados)

Overhead costs that have eventually been attached to cost objects by measures of allocation. Cost allocation refers to taking costs from one area or department, such as administration costs, and allocating them to another department or cost object.

Inputs

Intrants
Insumos

Goods, services, personnel and other resources provided for an activity with the purpose of producing output, and achieving the activity's objective.[3]

Internal Control

Contrôle interne
Control interno

The plan of organization of all the coordinated methods and measures adopted within a business to safeguard its assets, check the accuracy and reliability of its accounting data, and promote operating efficiency.

Licensing

Agrément
Acreditación

Legal permission to deliver services based on receiving certification.

Line Item Budget

Budget par poste
Presupuesto por partidas

A payment method where the unit of service is a set of functional budget categories usually on an annual basis. Can be either retrospective or prospective. Examples of resource categories include salaries, medicines, equipment, food, overhead, and administration.

Living Standards Measurement

Mesure du niveau de vie
Encuesta de niveles de vida (ENV)

World Bank extensive household survey to collect data to be used for developing new methods to monitor progress in raising levels of living, to identify the consequences for households of past and proposed government policies, and to improve communications between survey statisticians, analysts, and policymakers.[9]

Managed Care

Soins coordonnés
Atención controlada

(1) Generally refers to personal health care that is financed through fixed annual payments per person and is subject to utilization management and review. The fact that providers can expect fixed amounts for their services acts as an incentive for containing costs and improving efficiency in delivering care. (2) The system of purchasing services where providers are given responsibility for ensuring that a defined population receives a defined set of services in a coordinated way.[12]

Managed Competition

Concurrence gérée
Competencia controlada

Government regulation of a health market that uses competition as the means to promote efficiency. The system that is being developed in the UK uses competition between providers; that which is proposed under the Dekker reforms in the Netherlands uses competition between purchasers as well. Both types of system use contracts for clinical services, the providers of which are in competition, with price, quality, and volume of services being taken into account. The regulatory framework within which the competition operates in such systems is controlled by the government. It is designed to achieve a number of policy objectives apart from improved efficiency. These include control on patterns of service provision, greater accountability of local managers, cost containment, political support for redeployment of and closure of surplus facilities, control of powerful professional groups and greater equity in service access.

Management Accounting

Comptabilité de gestion
Contabilidad de gestión

Focuses on internal use of information within the enterprise and is the process of identification, measurement, accumulation, analysis, preparation, interpretation, and communication of information that assists executives in fulfilling organizational goals.

Management by Exception

Gestion par exception(s)
Gestión por excepción

The practice of concentrating on areas or processes within the organization that deserve attention and ignoring areas that are presumed to be running smoothly.

Management Control System

Système de contrôle de gestion
Sistema de control de la gestión

A means of gathering data to aid and coordinate the process of making decisions throughout the organization.

Means Testing

Contrôle (du niveau) des ressources
Comprobación de recursos económicos

An administrative mechanism that identifies an individual's income for purposes of establishing eligibility for benefits or services, such as health care, at no charge or reduced charge. By identifying individuals who are unable to pay and granting fee waivers (or reductions) to them, this mechanism is one of the principal approaches that can be used to protect the poorest under health sector cost recovery programs.[6]

Medically Necessary Care

Soins médicalement nécessaires
Atención médica necesaria

Treatment certified by a doctor as needed for the beneficiary's health and well-being. Insurers often reserve the right to determine whether the care a beneficiary claims insurance payment for is medically necessary.

Moral Hazard

Risque subjectif
Riesgo subjetivo

(1) The situation in which someone who acquires insurance changes their behavior because they no longer bear the full cost of that behavior. (2) Impact on an individual's demand for care of an out-of-pocket payment that is less than the cost of providing services. Because insurance (including centrally tax-funded services) covers some or all of the costs of service use, individuals tend to use more services than if they faced the full cost of care.

Morbidity

Morbidité
Morbilidad

(1) A measure of disease incidence or prevalence in a given population, location, or other grouping of interest.[11] (2) Illness, injury, or other than normal health. Often used in describing a rate (statistical term). One type of hospital morbidity rate, for example, is the postoperative infection rate, meaning the number of patients with infections following surgery, expressed as a proportion of those undergoing surgery.

Mortality

Mortalité
Mortalidad

(1) A measure of deaths in a given population, location, or other grouping of interest.[11] (2) A term that pertains to death. Usually used in the phrase "mortality rate," which means the number of patients who died expressed as a proportion of those at risk; for example, a mortality rate of 1 percent for appendectomy would mean one death per one hundred patients undergoing that operation. Mortality rates for more rare events are often given as per 10,000 or per 100,000.

National Health Expenditures

Dépenses nationales de santé
Gasto nacional en salud

Total spending on health services, prescription and over-the-counter drugs and products, nursing home care, insurance costs, public health spending, and health research and construction.[11]

Net Present Value (NPV)

Valeur actuelle nette (VAN)
Valor neto actual (VNA)

The present or current value of a series of receipts less the present or current value of a series of payments made over time.

Non-controllable Costs

Coûts non maîtrisables
Costos no controlables

Those costs that cannot be controlled by a manager. Generally, as an individual moves upward in a health care organization's management structure, costs become more controllable by that individual. As one moves downward in the structure, more and more of the entity's total costs become non-controllable to the individual. Department managers generally have control over their direct costs and little, if any, control over the overhead that has been allocated to their area.

Official Development Assistance (ODA)

Aide officielle au développement (AOD)
Asistencia oficial para el desarrollo (AOD)

Concessional financing, including grants, provided for external development by governments, either bilaterally or multilaterally.[3]

Opportunity Cost

Coût d'opportunité
Costo de oportunidad

The cost or rate of return of the best alternative investment that is available.

Out-of-pocket Maximum

Maximum à la charge du patient
Máximo desembolso en efectivo

The maximum amount of money that a beneficiary must pay in cost sharing per time period. Once that amount is reached, the insurer pays 100% of additional charges.

Outcome Standards

Normes de résultats
Estándares de resultados

Long-term objectives that define optimal, measurable future levels of health status, maximum acceptable levels of disease, injury, or dysfunction, or prevalence of risk factors.[11]

Output

Résultat(s)
Resultado

The product(s) that an activity is expected to produce from its inputs in order to achieve its objectives; the quantity of goods or services produced in a given time period.[3]

Overhead Costs

Frais généraux
Gastos generales

Indirect costs that are not easily associated with individual patients, procedures, activities, or services and, by their very nature, cannot be specifically identified to a given output. Overhead costs are costs that frequently require some form of aggregated allocation to cost objects. Typical examples of overhead departments include such areas as accounting, human resources, administration, security, and facility/building maintenance.

Pareto Rule

Loi de Pareto
Regla de Pareto

(1) Also known as the 80/20 rule. This is a rule of thumb indicating that 80 percent of the resources are utilized in activities that produce only 20 percent of the procedures or output. Employing the 80/20 rule focuses the costing effort on those areas that have the highest impact on resource use. (2) A principle that states that in any series of steps in a process, such as the diagnosis of a patient's problem, there are a "vital few" steps and a "trivial many." This principle makes feasible productive efforts at quality improvement since, through a "Pareto analysis," the vital few steps where efforts pay off can be identified, and action taken. It also is the key to optimizing the care possible under a condition of limited resources. The principle was developed by J.M. Juran, an authority on quality, and named after an Italian economist named Pareto.

Payback Method

Méthode de l'amortissement
Método de recuperación

A form of break-even analysis. Capital budgeting method that measures the time it will take to recoup, in the form of cash inflow from operations, the total dollars invested in a project.

Payer

Payeur
Pagador

(1) Any entity that pays for health care services. It is usually an insurer or government agency, but it can be one provider paying another or a self-insured employer paying providers. See also fundholder. (2) An organization or person who furnishes the money to pay for the provision of health care services. A payer may be the government (for example, Medicare), a nonprofit organization (such as Blue Cross and Blue Shield), commercial insurance, or some other entity. In common usage, payer most often means third party payer.

Per-Case Payment

Paiement par cas (traité)
Pago por caso específico

A fixed payment covering all services for a specified case or illness. Patient classification systems group patients according to diagnoses, major procedures performed (e.g., DRGs). Most frequently applied to inpatient services,

although outpatient groupers are being developed.

Per Capita Payment

Paiement par personne
Pago per cápita

A prospective payment method where the unit of service is the individual. A specific amount is paid per enrollee in an insurance plan or per person for a population target group to cover the costs of a defined package of services for a specified period of time.

Per Diem Payment

Paiement par journée d'hospitalisation
Pago diario

An aggregate payment covering all expenses incurred during one inpatient day.

Performance Reports

Comptes rendus sur les performances
Informes de desempeño

Reports that measure activities. These reports usually consist of comparisons of budgets with actual results and link them with volume and other productivity indicators.

Portability

Transférabilité
Transferibilidad

An arrangement under which an enrollee may change from one insurer to another without any delay in the beginning of coverage. This provision comes into operation when someone changes jobs or moves to a new location where the previous insurance coverage is no longer available.

Pre-paid Health Plan

Plan de santé à remboursement anticipé
Plan de salud prepagado

contract between a health unit (or group of units) and a person (or group of persons) that entitles the person(s) to receive certain types of health services for a fixed price paid in advance. The contract may or may not include additional payments that vary with the services provided to the persons enrolled in the plan.

Premium

Prime
Prima

(1) Amount of money paid to insurers on a regular basis in return for coverage (membership in an insurance plan). Premium rates for health insurance may be based on average costs of claims of the covered population or vary by socio-demographic characteristics such as age, sex, and occupational activity. (2) An amount paid for an insurance policy for a given period of time.

Prepayment

Remboursement anticipé
Prepago

(1) Payment made in advance giving a guarantee of eligibility to receive a service when needed at reduced or zero additional cost at time of use (e.g., insurance premiums, membership dues, crop share contributions).[13] (2) Payment in advance. A fee is paid a third party payer, such as a health maintenance organization (HMO), Blue Cross/Blue Shield, or commercial insurance, and the third party agrees to pay for stipulated care when it is provided. The voucher system now being put in place for Medicare is a prepayment system.

Present Value

Valeur actuelle
Valor actual

The value today of a future payment, or stream of payments, discounted at the appropriate discount rate.

Preventive Services

Services préventifs
Servicios preventivos

Services intended to prevent the occurrence of a disease or its consequences.[11]

Primary Care

Soins primaires
Atención primaria

(1) Primary care refers to personal, curative or preventive health care services that people need to address 80-90% of their health complaints. (2) The care provided by a primary physician. Care requiring more specialized knowledge or skill is obtained by referral from the primary care physician to the specialist (secondary care physician) for consultation or continued care. See also secondary care and tertiary care. (3) It is the first level of contact with people taking action to improve health in a community. The concept of primary health care worldwide has been transformed by the WHO policy of health for all. This defined primary health care more broadly than hitherto and saw it as an integral part of social and economic development. As the central part of health for all strategy primary health care is essential health care made accessible at a cost the country can afford, with methods that are practical, scientifically sound, and socially acceptable. Everyone in the community should have access to it and everyone should be involved in it. Related sectors should also be involved in addition to the health sector. At the very least it should include education for the community on the health problems prevalent and on methods of preventing health problems from arising or of controlling them; the promotion of adequate supplies of food and proper nutrition; sufficient safe water and basic sanitation; maternal and child health care, including family planning; the prevention and control of local endemic diseases; appropriate treatment of common diseases; and the provision of essential drugs. WHO sees primary health care as the central function and the main focus of a country's health system. It is an integral part of the social and economic development of a country. The essence of the difference between the WHO concept of primary health care and the concept of basic health services is that primary health care is a process concerned with equity, intersectoral action, community participation, and involvement for securing health gain. It is not merely the professional delivery of medical care at local level. Involvement means that individuals and families assume responsibility for their, and the community's health and welfare and develop the capacity to contribute to their own and the community's development. The WHO concept of PHC assumes that investment in this process of primary health care is more efficient, effective, acceptable, and sustainable than other ways of promoting health gain within local communities. The concept is consistent with the core values increasingly seen as essential to development: life sustenance, self esteem, and freedom to be able to choose.

Private Sector

Secteur privé
Sector privado

That part of the economy in which economic activity is carried out by private enterprise and nongovernmental organizations (NGOs).[3]

Privatization

Privatisation
Privatización

The process of introducing private financing and/or ownership into government entities. This could include policy and legal frameworks, as well as implementation of some aspect of private health care service delivery.

Product Line

Ligne de produit
Línea de productos

A group of patients that have some commonality that allows them to be grouped together, such as a common diagnosis.

Profit Center

Centre de responsabilité pour les bénéfices
Centro de utilidades

Responsibility center in which a manager is accountable for revenues and costs.

Prospective Payment

Paiement prospectif
Pago previsto

(1) Refers to when the payment rate for a package of health care services is negotiated and agreed upon before the treatment takes place. Prospectively set payment rates increase incentives for efficiency because the health provider faces higher financial risk. Examples include case-based payment and per capita-based payment when the rates are set in advance of services actually being rendered. (2) That element of a payment scheme whose level is fixed in advance of actually providing a service. (3) A term that actually means "prospective pricing system." The generic term for the system currently in use for paying for services for Medicare patients under the Diagnosis Related Group (DRG) program. The idea is that patients are classified into categories (in this case, DRGs) for which prices are negotiated or imposed on the hospital in advance. At present this kind of system is only applied to hospital care, not physician care, although the idea is the same as a single fixed "package" fee that includes prenatal care, delivery, and postpartum care for a maternity patient, or the inclusion of preoperative care, surgery, and postoperative care for an appendectomy patient within one fixed physician's fee. See also retrospective payment.

Protocols

Protocole(s)
Protocolos

(1) Rules agreed in advance that are to be followed in decision making unless an exception is sought.[12] (2) Plans of treatment or case management.

Provider

Prestataire (de soins)
Proveedor

(1) The health service facility or health service worker, e.g., a hospital, a general practice clinic, an individual doctor, a nurse.[12] (2) A hospital or health care professional who provides health care services to patients. May be a single

hospital, an individual, or a group or organization.

Provider Payment Mechanisms

Mécanismes de paiement des prestataires
Mecanismos de pago a proveedores

Provider payment is the way in which money is distributed from a source of funds, such as the government, insurance company, or other fundholder, to a health institution.

Public Health

Santé publique
Salud pública

Activities that society does collectively to assure the conditions in which people can be healthy. This includes organized community efforts to prevent, identify, preempt, and counter threats to the public's health.[11]

Public Sector

Secteur public
Sector público

That part of the economy of a country that comes within the scope of central government, local government authorities and public corporations.[3]

Quality Assurance

Assurance de la qualité
Control de calidad

(1) A formal, systematic process to improve quality of care that includes monitoring quality, identifying inadequacies in delivery of care, and correcting those inadequacies. (2) Monitoring and maintaining the quality of public health services through licensing and discipline of health professionals, licensing of health facilities, and the enforcement of standards and regulations.[11] (3) The efforts to determine the quality of care, to develop and maintain programs to keep it at an acceptable level, and to institute improvements when the opportunity arises or the care does not meet standards. The term "quality assurance" is being replaced by "quality management." The advantages of the term "quality management" are (a) there is no implication of a "guarantee," an idea that may be suggested by the use of the word "assurance," which is sometimes used as a synonym for "insurance;" and (b) "quality management" is more accurate, since the achievement of quality depends on people carrying out their responsibilities without error, and getting people to perform is the task of management.

Quality of Care

Qualité des soins
Calidad de la atención

(1) The quality of technical care consists of the application of medical science and technology in a way that maximizes its benefits to health without correspondingly increasing its risks. The degree of quality is, therefore, the extent to which the care provided is expected to achieve the most favorable balance of risks and benefits.[15] (2) The degree of conformity with accepted principles and practices (standards), the degree of fitness for the patient's needs, and the degree of attainment of achievable outcomes (results), consonant with the appropriate allocation or use of resources. The latter phrase carries the concept that quality is not equivalent to "more" or "higher technology" or higher cost. The "degree of conformity" with standards focuses on the provider's performance, while the "degree of fitness" for the patient's needs

indicates that the patient may present conditions that override strict conformity with otherwise prescribed procedures.

Recurrent/Operating Costs

Charges récurrentes
Gastos operativos recurrentes

Costs that occur on a regular timely basis, such as those involved in running a clinic, for example, payment of salaries of doctors and nurses and purchase of medicinal drugs.[3]

Reimbursement

Remboursement
Reembolso

(1) Payment to a health facility or physician from the government, insurance company, or other fundholder for services rendered. (2) The payment to a hospital, other provider, or anyone, after the fact, an amount equal to the institution's or individual's expenses. The current trend is, of course, away from such a "blank check" approach, toward a prospective pricing system. Several varieties of reimbursement are discussed in health care:

Cost-based Reimbursement:

Remboursement sur le base du coût
Reembolso basado en costos

Payment of all allowable costs incurred in the provision of care. The term "allowable" refers to the terms of the contract under which care is furnished.

Prospective Reimbursement:

Remboursement anticipé
Reembolso prospectivo

A term sometimes used incorrectly instead of prospective pricing or prospective payment. Also, "prospective reimbursement" is sometimes used to describe the prospectively estimated amount to be paid a hospital on a current schedule so that it will have operating cash, with the understanding that adjustments will be made later in the light of actual operating cost data. The concept is similar to that of the periodic interim payment (PIP).

Retroactive Reimbursement:

Remboursement rétroactif
Reembolso retroactivo

Additional payment to a provider for costs not considered at the time of initial reimbursement.

Retrospective Reimbursement:

Remboursement rétrospectif
Reembolso retrospetivo

Payment based on actual costs as determined at the end of the fiscal period.

Relative Value

Valeur relative
Valor relativo

Index number assigned to a procedure based upon the relative amount of labor, supplies, and capital needed to perform the procedure.

Relative Value Unit (RVU) Costs

Coûts unitaires en valeur relative
Costos de la unidad de valor relativo

(1) This is a methodology for costing where the resources of one procedure, product, activity, or

service (cost object) are measured "relative" to one another. By establishing a hierarchy of the relative consumption of resources among cost objects, total costs can be assigned to all cost objects according to their relative value adjusted for their frequency of occurrence. (2) A numerical figure designed to make possible comparisons of the resources needed (or appropriate prices for) various units of service. An RVU takes into account labor, skill, supplies, equipment, space, and so on, into an aggregate cost for a procedure or other unit of service. This cost is converted into the RVU of the procedure or service by relating it to the cost of procedure or service selected as the "base." For example, a red blood count might be used as the base and thus have an RVU of 1.0. If a blood sugar determination were, say, five times as "costly," it would have an RVU value of 5.0 (the illustration is imaginary as to the values given).

Relevant Costs

Coûts pertinents
Gastos pertinentes

Expected future costs that directly result from the proposed new project or investment.

Reproductive Health

Santé de la reproduction
Salud reproductiva

Providing access and choice in family planning; caring for women before, during, and after pregnancy; preventing and controlling sexually-transmitted diseases, including HIV; preventing and treating cervical cancer; promoting the health of adolescents; and supporting positive health practices.[2]

Resource Allocation

Allocation des ressources
Asignación de recursos

In general, assignment of scarce inputs to the production of outputs.[3]

Responsibility Centers

Centres de responsabilité
Centros de responsabilidad

Parts, segments, or subunits of an organization whose managers are accountable for a specified set of activities.

Retrospective Payment

Paiement rétrospectif
Pago retrospectivo

(1) Refers to when the payment rate is selected during or after the service has been rendered, sometimes as cost-based reimbursement, and is well known for being cost-enhancing rather than cost-reducing. Fee-for-service is a typical form or retrospective reimbursement. Although prices for each service may be set in advance, providers are not limited by a pre-determined agreement on the types and number of services rendered. (2) That element of a payment scheme whose level is determined only after services have been provided. See also prospective payment.

Revenue Planning

Planification des revenus
Planificación de ingresos

Plotting future income.[13]

Risk

Risque(s)
Riesgo

(1) The unexpected but estimated loss an insurer considers in issuing a contract to cover the loss in the event that it occurs. (2) The possibility of financial loss because of an injury to a patient (or visitor or employee), either through custodial liability (such as slips and falls) or professional liability (harm from the medical or hospital care). (3) Health care plan risk is a term which, when used in connection with organizations for providing patient care, refers to finances. For example, a health maintenance organization (HMO) that offers prepaid care for a given fee or premium is "at risk;" it must provide the care within the premium funds available or find the money elsewhere (the individual assets of the partners, for example).

Risk Assessment

Evaluation des risques
Evaluación de riesgos

The means by which plans and policymakers estimate the anticipated but uncertain claims costs of enrollees.[11] This includes careful analysis of the probability of various health care costs that might be incurred by the individuals enrolled in the health insurance.

Risk Pool

Pools de risques
Mancomunación de riesgos

A fund set up as a reserve for unexpected expenses. Organizations providing prepaid health care for a fixed fee typically set up such pools to cover, for example, unusually large demands for hospital care or specialist services.

Risk Selection

Sélection des risques
Selección de riesgo

An insurer's attempts to enroll a population that will have lower-than-average risk. Risk selection refers to decisions by the insurer as to who to enroll; adverse selection refers to decisions by the enrollee as to whether to buy coverage.

Risk Sharing

Partage des risques
Riesgos compartidos

(1) Usually the distribution of the risk or probability of health expenditures among members of the population, whether they are healthy or ill.[3] Within the memberships group, some individuals will require health care services while others will not. (2) The division of financial risk among those furnishing the service. For example, if a hospital and group of physicians form a corporation to provide health care at a fixed price, they will ordinarily do it under an arrangement in which the hospital and physicians are both liable if the expenses exceed the revenue; that is, they share the risk.

Salvage Value

Valeur de récupération
Valor de rescate

The value of a capital asset at the end of a specified period.

Secondary Care

Soins secondaires
Atención secundaria

(1) Care from specialists that ideally is arranged through referral after preliminary evaluation by

a primary-care practitioner.[1] (2) Specialized care provided by a physician or hospital, usually on referral from a primary care physician. (3) Hospitals and outpatient specialist clinics, to which people go after referral from primary health care services. These services are generally more specialized and further from where people live. They often include a greater range of diagnostic services such as x-ray and pathological laboratory services; they may also include specialized treatment such as operating theaters and radiotherapy and certain drug therapies not normally available in primary care. The principal difference between primary and secondary services is in the range and specialization of the staff available.

Sector Program Assistance (SPA)

Assistance par programme sectoriel (APS)
Asistencia para proyectos sectoriales

Providing cash and grant assistance as program benchmarks are achieved.

Semi-variable Costs

Coûts semi-variables
Costos semivariables

Some costs have certain characteristics of both fixed and variable costs. These are also referred to as "mixed costs." Telephone costs is an example, in that there is a fixed monthly based rate augmented by a variable rate that increases as long distance calls are made.

Service Benefits

Prestations sous forme de services
Prestaciones de servicios

Insurance benefits that are the health care services themselves, rather than money. Service benefits are traditional with Blue Cross/Blue Shield and Medicare; indemnity benefits are usual with commercial insurance.

Skim (Cream Skim)

Écrémage
Descremado

A term which, in hospital usage, usually means to select patients who will be financially profitable; for example, because they have an illness for which the prospective payment system (PPS) favors the hospital, or because they have insurance and are not charity patients.

Social Cost

Coût social
Costo social

Cost to society, and not merely to the individual or agency carrying out the activity, that do not appear in financial accounts (e.g., the costs of air pollution, noise, congestion).13

Social Financing

Financement social
Financiamiento social

Funds are drawn from society at large to pay for an array of health care benefits offered at little or no out-of-pocket charge to a particular group of people or to all members of society. Social financing can be paid for from general tax revenues (as in services provided by ministries of health around the world); from mandatory health taxes specific to (earmarked for) health (as in the health component of social security in South America, the Caribbean, and Asia); or from compulsory contributions, established by law, to a public or private health fund other than social security.[5]

Stakeholders

Parties concernées
Partícipes

Those individuals or entities interested in or potentially affected by a planned intervention in a program or project.[8]

Standard Benefits Package

Paquet de prestations standard
Paquete de prestaciones estándar

(1) A core set of health benefits that everyone in a country should have through their employer, a government program, or a risk pool. (2) A defined set of health insurance benefits that all insurers are required to offer.[11]

Straight-line Depreciation

Amortissement linéaire
Depreciación lineal

Depreciation method in which an equal amount of depreciation is taken each year.

Structural/Economic Adjustment

Ajustement structurel/ajustement économique
Ajuste económico estructural

The set of measures aimed at achieving the longer term objective of accelerating economic growth chiefly by restructuring the economy and reducing excessive or inefficient government intervention.[3]

Subsidy

Subvention
Subvención

(1) A grant of money to an organization or an individual from a government or other agency.[13] (2) A payment made by the government with the object of reducing the market price of a particular product or of maintaining the income of the producer. The aim of a subsidy may be to sustain demand for a particular product; to protect a particular industry; or to ensure that those consumers, especially the poor, who would otherwise not purchase a product or whose demand for it would decline, maintain their previous level of consumption.

Sunk Costs

Coût irrécupérables
Costo no recuperables

Past costs that are unavoidable because they cannot be changed no matter what action is taken. They are not included in profitability analyses of future investments.

Sustainable Development

Développement durable
Desarrollo sustenable

The capacity to meet the needs of the present without compromising the ability to meet future needs. This concept is central to current thinking on global protection and overcoming the threats to health presented by industrial growth and exploitation of natural resources. The idea of sustainable development contains two basic concepts, as defined by the World Commission on Environmental Development-the Brundtland Commission. These are the concept of needs, in particular the essential needs of the world's poor, to which overriding priority should be given; and secondly the idea of limitations imposed by the state of technology and social organization on the environment's ability to meet present and future needs. The Brundtland Commission went on to say that physical sustainability cannot be secured unless development policies pay

attention to such considerations as changes in access to resources and in the distribution of costs and benefits. The notion of physical sustainability implies a concern for social equity between generations, a concern that must logically be extended to equity within each generation. It is generally now well accepted in development policy that poverty, health, environmental degradation, and population growth are inextricably related and that none of these fundamental problems can be successfully addressed in isolation. They are all part of the challenge of sustainable development. A special aspect of sustainability is sustainability of development programs; this can be said to have been achieved when a program continues to deliver intended recurring benefits after the cessation of the original development assistance on which the development at first depended. Achieving sustainable health development through foreign aid is a special challenge in the health sector.

Targeting

Ciblage
Focalización

The general process of channeling benefits such as food or health care to a specific (target) population group such as the poor, women or children. It is usually compared with offering services to everyone free-of-charge (i.e., through a general price subsidy). Means testing is but one of a number of targeting mechanisms.[6]

Tertiary Care

Soins tertiaires
Atención terciaria

(1) Care of a highly technical and specialized nature, provided in a medical center, usually one affiliated with a university, for patients with unusually severe, complex, or uncommon problems. (2) Specialized care that offers a service to those referred from secondary care for diagnosis or treatment and that is not available in primary or secondary care. This kind of care is generally only available at national or international referral centers. Tertiary care has become a common feature in certain specialities for rare conditions or where the diagnostic or treatment facilities are scarce or require scarce combinations of resources or which remain essentially the subject of research. These facilities are commonly found in medical schools and teaching hospitals. The presence of such rare conditions and facilities can have an adverse impact on teaching if the principal operational role for most health professionals once qualified is primary care.

Tertiary Center

Secteur tertiaire
Centro terciario

A large medical care institution, usually a teaching hospital, that provides highly specialized care.[11]

Third Party Payer

Tiers payant
Tercer pagador

(1) Intermediary institution responsible for paying providers for services rendered to covered patients. Such funds or purchasers are called third party payers because they are neither patients nor health care providers. (2) An intermediate institution (e.g., insurance company) that modifies the transactions between consumers and providers of health care. Third party payers can be the government or private sector companies. (3) A payer who

neither receives nor gives the care (the patient and the provider are the first two parties). The third party payer is usually an insurance company, a prepayment plan, or a government agency; organizations that are self-insured are also considered third parties.

Total Quality Management (TQM)

Maîtrise de la qualité totale
Gestion calidad total

An approach to quality assurance that emphasizes a thorough understanding by all members of a production unit of the needs and desires of the ultimate service recipient, a viewpoint of wishing to provide service to internal, intermediate service recipients in the chain of service, and a knowledge of how to use specific data-related techniques to assess and improve the quality of their own and their team's outputs.

Unit Cost or Rate Variance

Coût unitaire ou variance du taux
Varianza de costo unitario o arancel

Difference (variance) due to the actual cost per unit or amount per unit differing from what was budgeted (or standards expected).

User Charges

Paiement par l'usager
Cargos a usuarios

Also, fees. Charges to be paid by the users of a service.[3]

Utilization Management and Review

Gestion et examen de l'utilisation
Gestión y revisión de utilización

Procedures to identify whether health care services are being provided inappropriately or in excess. Managed care organizations make extensive use of these procedures in order to reduce utilization of services and costs. Some examples of utilization management include gatekeeping, referrals, and second opinion requirements. Some examples of utilization review include profiling and physician peer review.[1]

Variable Costs

Coûts variables
Costos variables

(1) Those costs that vary directly or proportionally with changes in volume or activity. X-ray film consumed in taking chest x-rays is a variable supply cost. As more chest x-rays are taken, more film is consumed. (2) Those costs that vary with the volume of output, unlike a fixed cost, which remains constant with variations in output.

Variances

Variances
Varianzas

Difference between actual financial results and budgeted amounts.

Volume Variance

Variance du volume
Varianza de volumen

Difference due to actual volume differing from what was originally budgeted. Flexible budgeting eliminates this variance.

Annex A: References

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